TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ved V Aggarwal MD PA

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-16-1112-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was originally denied due to "Extent of Injury", the bill claim was filed with Diagnosis 724.2 & 724.8. Both diagnosis do pertain to the injury."

Amount in Dispute: $113.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent maintains it position no reimbursement is owed to Requestor because they examined, treated and prescribed medication for a disputed condition. Respondent specifically indicates he is prescribing medication for RSD. …In conclusion, no reimbursement should be awarded to Requestor because he treated a non-compensable condition."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2015	99213	$113.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out general guidelines for medical fee dispute resolution.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – Based on extent of injury

Issues

1. Did the requestor resolve the dispute for work related illness or injury?

Findings

1. The insurance carrier denied dates of service July 13, 2015 based on denial reason code "219 – Based on extent of injury," during the medical bill review process. The date of service referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, dates of service July 13, 2015 were not considered in this review.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		March , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.